Inside This Issue of JACC

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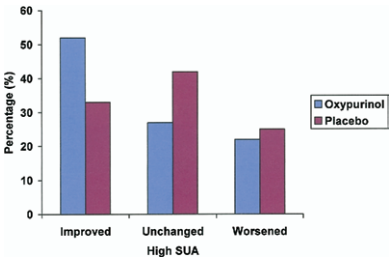

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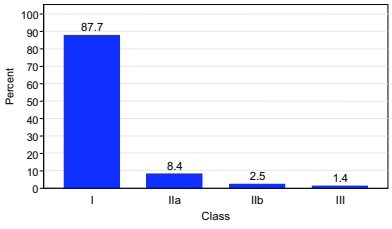
Clinical Trials

Oxypurinol May Benefit Congestive Heart Failure Patients With High Uric Acid

Xanthine oxidase (XO) is elevated in heart failure and contributes to vasoconstriction and myocardial dysfunction. The OPT-CHF trial randomized over 400 class III to IV heart failure patients to either the XO inhibitor, oxypurinol, or placebo, and followed them for 24 weeks with a composite end point comprising morbidity, mortality, and quality of life. When all subjects were included, there were no significant differences between oxypurinol and placebo. However, those subjects with elevated baseline uric acid (>9.5 mg/dl) did benefit, while those with low or normal uric acid levels worsened. Oxypurinol is not useful in unselected patients with class III to IV heart failure, but may be beneficial in those with elevated uric acid levels. **See pages 2301 and 2310. See figure.**



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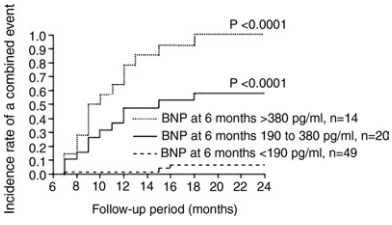
Coronary Artery Surgery

No Evidence of Widespread Inappropriate CABG Surgery

There is substantial geographic variability in the population-based rates of coronary artery bypass graft (CABG) surgery, but the rate of inappropriate CABG is unknown. O'Connor and colleagues used the American College of Cardiology/American Heart Association 2004 guidelines to classify the appropriateness of nearly 5,000 CABG surgeries from 8 hospitals: Class I (useful and effective), Class II, or Class III (not useful or effective). The vast majority of procedures were Class I (88%). Class II procedures totaled 11%, and the remaining 1.4% procedures were Class III. In this regional study, 98.6% of CABG procedures were considered to be appropriate by published guidelines. **See page 2323. See figure.**



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Heart Failure

BNP Useful for Stratifying Stable Heart Failure Patients

Nishii and colleagues studied the utility of measuring B-type natriuretic peptide (BNP) in patients with non-ischemic dilated cardiomyopathy (NICM) who had been stable and asymptomatic for at least 6 months. The main end point was rehospitalization or death over the next 18 months. The risk of rehospitalization or death increased with higher BNP levels; the hazard ratios for those with BNPs 190 to 380 pg/ml and >380 pg/ml were 5 and 11.5, respectively, compared with those with a BNP <190 pg/ml. These results show that in stable, apparently low-risk outpatients with NICM, the BNP level 6 months after hospital discharge predicts the long-term risk of decompensation. **See pages 2329 and 2336. See figure.**

Biomarkers

CRP Level Does Not Predict Outcomes Post-ACS

Elevated inflammatory markers may reflect a more active atherosclerotic substrate and thereby identify patients at increased risk. Bogaty and colleagues measured C-reactive protein (CRP) at hospital admission, discharge, and 1 month after discharge from over 1,200 patients with acute coronary syndomes (ACS). The primary outcome was a composite of death and ACS over the next year. The unadjusted odds ratios were weakly positive for CRP values at admission and 1 month, but not at hospital discharge. After adjusting for age, heart failure symptoms, diabetes, and electrocardiogram changes, CRP levels added no further predictive information. The modest predictive ability of CRP following admission for an ACS disappears after adjusting for common clinical variables. **See page 2339.**